Live Smarter Nutrition & Wellness
P.O. Box 24
Morgan, PA 15064
Telephone: (513) 317-9746
Email: livesmarternutrition@gmail.com

Nutrition Assessment / Initial Intake form

Date: _____

Name: _____

Email Address: _____

Address – Street: _____

City: _____ State: _____ Zip Code: _____

Preferred telephone: _____ Please indicate: [ ] Home [ ] Mobile [ ] Work

Birth Date: _____ Age: _____ Sex: [ ] Male [ ] Female

Height: ____ feet ___ inches Profession: _____

Have you previously received nutrition counseling? [ ] Yes [ ] No

Current Body Weight ____ Highest Adult Weight ___ Lowest Adult Weight ____

Medical History: _____

Current Medications (please include vitamins and other supplements as well):

_____

If desired, please provide the names of any of the following professionals with whom you are working:

Primary care physician: _____

Psychiatrist: _____

Therapist/counselor: _____

Trainer: _____

Other health professionals (include relationship): _____

Goals for nutrition counseling:

_____

Please provide the following insurance information if you wish to submit payment through your insurance company. Your health insurance may or may not cover nutrition counseling services. Payment/reimbursement depends on your individual coverage and your diagnosis.

Insurance Company: _____ Insurance Plan: _____

Member ID Number: _____Group Number: _____

Insurance Co. Address

Street: _____

City: _____ State: ____ Zip Code: _____

Insurance Co. Telephone: _____